CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 15:015. Reimbursement provisions and requirements for behavioral health services provided by independent providers.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23).

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. For the department to reimburse for a service covered under this administrative regulation, the service shall be:

(1) Medically necessary;

(2) Provided:

(a) To a recipient; and

(b) By a:

1. Provider who meets the provider participation requirements established in 907 KAR 15:010; or

2. Practitioner working under the supervision of a provider who meets the provider participation requirements established in 907 KAR 15:010;

(3) A service covered in accordance with 907 KAR 15:010; and

(4) Billed to the department by the billing provider who provided the service or under whose supervision the service was provided by an authorized practitioner in accordance with 907 KAR 15:010.

Section 2. Reimbursement. (1) One (1) unit of service shall be fifteen (15) minutes in length or the unit amount identified in the corresponding current procedural terminology code.

(2) The rate per unit for a screening shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(3) The rate per unit for an assessment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician

Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(4) The rate per unit for psychological testing shall be:

(a) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychologist; or

(b) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological practitioner; or

(c) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service.

(5) The rate per unit for screening, brief intervention, and referral to treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(6) The rate per unit for crisis intervention shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical

social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(7) The rate per unit for service planning shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(8) The rate per unit for individual outpatient therapy shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(9) The rate per unit for family outpatient therapy shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician

Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(10) The rate per unit for group outpatient therapy shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing

provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(11) The rate per unit for collateral outpatient therapy shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(12) The rate per unit for medication assisted treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist; or

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an advanced practice registered nurse.

(13) The rate per unit for day treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(14) The rate per unit for comprehensive community support services shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health

professional.

(15) The rate per unit for peer support services shall be 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(16) The rate per unit for parent or family peer support services shall be 52.5 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(17) The department shall not reimburse for a service billed by or on behalf of an entity or individual that is not a billing provider.

Section 3. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a community mental health center.

Section 4. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 15:010; and

(2) This administrative regulation.

Section 5. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

907 KAR 15:015

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 15:015

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 15:015
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working under for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization. This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:010 (Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15). Currently, the Department for Medicaid Services does not enroll licensed psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, or licensed psychological practitioners as independent Medicaid providers. Rather these providers have to work for or under contract with - for example - a community mental health center, a physician's office, a federally-qualified health center, or a rural health clinic among other entities and the entity bills (and is reimbursed by) the Medicaid Program for the services provided. This administrative regulation also establishes practitioners who may provide behavioral health services under supervision of one (1) of the aforementioned independent providers and in which case the Medicaid Program will reimburse the independent provider (billing provider) for the services.

(b) The necessity of this administrative regulation: This administrative regulation is being promulgated in conjunction with two (2) administrative regulations – 907 KAR 15:010 (Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15) - to comply with a federal mandate and to enhance recipient access to services. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. Currently, DMS covers substance use treatment for pregnant women and children. Additionally, this administrative regulation is necessary to enhance Medicaid recipient access to behavioral health services by expanding the providers and practitioners authorized to provide the services as independent providers or as practitioners working under the supervision of an independent provider. The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining

Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the “expansion group” (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the “old” Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by complying with a federal mandate and by enhancing and ensuring Medicaid recipients’ access to behavioral health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by complying with a federal mandate and by enhancing and ensuring Medicaid recipients’ access to behavioral health services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological practitioners who wish to enroll in the Medicaid Program as independent providers will be affected by this administrative regulation. Licensed psychological associates, certified social workers (master’s level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide behavioral health services while working for one (1) of the aforementioned independent providers will also be affected by this administrative regulation. Medicaid recipients who qualify for behavioral health services will be affected by this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals listed in question (3) who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Individuals who wish to provide behavioral health services to Medicaid recipients per this administrative regulation could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An individual who enrolls with the Medicaid Program to provide behavioral health services will benefit by being reimbursed for services provided to Medicaid recipients. Behavioral health service practitioners who can work for an independent behavioral health service provider will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(b) On a continuing basis: The response to question (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be

necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the policies apply equally to the regulated entities..

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 15:015
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), and 42 U.S.C. 1396a(a)(30)(A).

2. State compliance standards. KRS 205.520(3) states:

“Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate.

Section 1302(b)(1)(E) of the Affordable Care Act mandates that “essential health benefits” for Medicaid programs include “mental health and substance use disorder services, including behavioral health treatment.”

42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to “provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.” Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization’s provider network.

The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky’s Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement.

42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: ". . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 15:015
Agency Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.
(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)
(d) How much will it cost to administer this program for subsequent years? The response to question (a) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: